I. PATIENT INFORMATION

Patient's Name (Last, First, M.I.): _____ Phone No.: ( ) _____

Address: _____ City: _____ County: _____ State: _____ Zip Code: _____

RETURN TO STATE/LOCAL HEALTH DEPARTMENT

Social Security No.: _____ *- Patient identifier information is not transmitted to CDC! -*

INDIANA STATE DEPARTMENT OF HEALTH
ADULT HIV/AIDS CONFIDENTIAL CASE REPORT

(Patients ≥13 years of age at time of diagnosis)

State Form 51201 (R/1-06)

DATE FORM COMPLETED: Month ☐☐ Day ☐☐ Year ☐☐

REPORT SOURCE: ☐☐

II. STATE HEALTH DEPARTMENT USE ONLY

SOUNDEX CODE: ☐☐☐☐

REPORT STATUS: 1 New Report; 2 Update

REPORTING HEALTH DEPARTMENT:

State: _____

City/ County: _____

State Patient No.: ☐☐☐☐☐☐☐☐☐☐

City/County Patient No.: ☐☐☐☐☐☐☐☐☐☐

III. DEMOGRRAPHIC INFORMATION

DIAGNOSTIC STATUS AT REPORT: (check one)

1 HIV Infection (not AIDS)

2 AIDS

AGE AT DIAGNOSIS: ☐☐ Years ☐☐ Years

DATE OF BIRTH: Month ☐☐ Day ☐☐ Year ☐☐

CURRENT STATUS: Alive 1 Dead 2 Unk. 9

DATE OF DEATH: Month ☐☐ Day ☐☐ Year ☐☐

STATE/TERRITORY OF DEATH: _____

SEX (at birth): 1 Male; 2 Female

SEX (current): ☐ Male; ☐ Female

ETHNICITY (select one): 1 Hispanic or Latino; 2 Not Hispanic or Latino; 9 Unknown

RACE (select one or more):

☐ American Indian or Alaska Native ☐ Asian ☐ Black or African American

☐ Native Hawaiian/or Other Pacific Islander ☐ White ☐ Unknown

COUNTRY OF BIRTH:

1 U.S.

7 U.S. Dependencies and Possessions (incl. Puerto Rico) (specify) _____

8 Other (specify): _____ 9 Unk.

RESIDENCE AT DIAGNOSIS:

City: _____ County: _____ State/Country: _____ Zip Code: ☐☐☐☐☐ - ☐☐☐☐

LIVED IN ANY OTHER STATE/COUNTRY?: State: _____ Country: _____

IV. FACILITY OF FIRST DIAGNOSIS

Facility Name _____

City _____

State/Country _____

FACILITY SETTING (check one)

1 Public 2 Private 3 Federal 9 Unknown

FACILITY TYPE (check one)

☐ (A02.03) Physician, HMO

☐ (A04.04) Case Mgt. Agency

☐ (A02.04) HRSA Clinic

☐ (A04.05) Counseling & Testing Site

☐ (A04.02) Drug treatment center

☐ (A02.08) Prenatal/OB clinic

☐ (A06.19) Correction facility

☐ (A01.01) Hospital, Inpatient

☐ (A02) Hospital, Outpatient

☐ (A010) Other (specify): _____

V. PATIENT HISTORY

AFTER 1977, AND PRECEDING THE FIRST POSITIVE DIAGNOSIS FOR HIV INFECTION OR AIDS, THIS PATIENT HAD (Respond to ALL Categories):

	Yes	No	Unk.
• Sex with male	1	0	9
• Sex with female	1	0	9
• Injected nonprescription drugs	1	0	9
• Received clotting factor for hemophilia/coagulation disorder	1	0	9

Specify disorder: 1 Factor VIII (Hemophilia A) 2 Factor IX (Hemophilia B) 8 Other (Specify): _____

	Yes	No	Unk.
• HETEROSEXUAL relations with any of the following:			
• Intravenous/injection drug user	1	0	9
• Bisexual male	1	0	9
• Person with hemophilia/coagulation disorder	1	0	9
• Transfusion recipient with documented HIV infection	1	0	9
• Transplant recipient with documented HIV infection	1	0	9
• Person with AIDS or documented HIV infection, risk not specified	1	0	9
• Received transfusion of blood/blood components (other than clotting factor)	1	0	9

First Mo. ☐☐ Yr. ☐☐ Last Mo. ☐☐ Yr. ☐☐

• Received transplant of tissue/organs or artificial insemination	1	0	9
• Worked in a health-care or clinical laboratory setting (specify occupation): _____	1	0	9

VI. LABORATORY DATA

1. HIV ANTIBODY TESTS AT DIAGNOSIS: (Indicate first test)

	Pos.	Neg.	Ind.	Not Done	Mo.	Day	Yr.
• HIV-1 EIA	1	0	-				
• HIV-1/HIV-2 combination EIA	1	0	-				
• HIV-1 Western blot/1FA	1	0	8				
• NAT (Nucleic Acid Test)	1	0	-				

2. POSITIVE HIV DETECTION TEST: (Record earliest test)

	Mo.	Day	Yr.
• HIV PCR, DNA, or RNA probe			
• NAT (Nucleic Acid Test)			

3. DATE OF LAST DOCUMENTED NEGATIVE HIV TEST (specify type): _____ Mo. ☐☐ Day ☐☐ Yr. ☐☐

4. IF HIV LABORATORY TESTS WERE NOT DOCUMENTED, IS HIV DIAGNOSIS DOCUMENTED BY PHYSICIAN? Yes 1 No 0 Unk. 9 Mo. ☐☐ Day ☐☐ Yr. ☐☐

5. IMMUNOLOGIC LAB TESTS: (At or closest to current diagnostic status)

		Month	Day	Year
• CD4 Count	☐.☐☐☐ cells/µL			
• CD4 Percent	☐☐ %			

First <200 µL or <14%

		Month	Day	Year
• CD4 Count	☐.☐☐☐ cells/µL			
• CD4 Percent	☐☐ %			

6. RESISTANCE TESTS:

	Month	Day	Year
• Genotyping (send copy)			
• Phenotyping (send copy)			

7. CTR / OPSCAN # _____

VII. PHYSICIAN INFORMATION

Physician's Name: _____ (Last, First, M.I.)
Phone No.: ( ) _____
Medical Record No.: _____

Name of Facility or Practice: _____
Complete Address: _____

Email: _____ FAX: ( ) _____
Person Completing Form: _____
Phone No.: ( ) _____

- Physician identifier information is not transmitted to CDC! -

VIII. VIRAL LOAD DATA*

Laboratory Name: _____

bDNA ____ NASBA ____ RNA PCR ____ Results _____ Date ____/____/____

bDNA ____ NASBA ____ RNA PCR ____ Results _____ Date ____/____/____

IX. CLINICAL STATUS

CLINICAL RECORD REVIEWED: Yes [1] No [0]

ENTER DATE PATIENT WAS DIAGNOSED AS:
ASYMPTOMATIC (including acute retroviral syndrome and persistent generalized lymphadenopathy): Mo [ ][ ] Day [ ][ ] Yr. [ ][ ]
Symptomatic (not AIDS): Mo [ ][ ] Day [ ][ ] Yr. [ ][ ]

AIDS INDICATOR DISEASES	Initial Diagnosis Def.	Initial Diagnosis Pres.	Initial Date Mo.	Day	Yr.
1) Candidiasis, bronchi, trachea, or lungs	1	NA			
2) Candidiasis, esophageal	1	2			
3) Carcinoma, invasive cervical	1	NA			
4) Coccidioidomycosis, disseminated or .extrapulmonary	1	NA			
5) Cryptococcosis, extrapulmonary	1	NA			
6) Cryptosporidiosis, chronic intestinal (>1 Mo. duration)	1	NA			
7) Cytomegalovirus disease (other than in liver, spleen, or nodes)	1	NA			
8) Cytomegalovirus retinitis (with loss of vision)	1	2			
9) HIV encephalopathy	1	NA			
10) Herpes simplex: chronic ulcer(s) (>1 mo. duration); or bronchitis, pneumonitis or esophagitis	1	NA			
11) Histoplasmosis, disseminated or extra pulmonary	1	NA			
12) Isosporiasis, chronic intestinal (>1 mo. duration)	1	NA			
13) Kaposi's sarcoma	1	2			
14) Lymphoma, Burkitt's (or equivalent term)	1	NA			
15) Lymphoma, immunoblastic (or equivalent term)	1	NA			
16) Lymphoma, primary in brain	1	NA			
17) *Mycobacterium avium* complex or M. Kansasii, disseminated or extrapulmonary	1	2			
18) *M. tuberculosis, pulmonary**	1	2			
19) *M. tuberculosis*, disseminated or extrapulmonary*	1	2			
20) *Mycobacterium*, of other species or unidentified species,disseminated or extrapulmonary	1	2			
21) *Pneumocystis carinii* pneumonia	1	2			
22) *Pneumonia*, recurrent, in 12 mo. period	1	2			
23) Progressive multifocal leukoencephalopathy	1	NA			
24) Salmonella septicemia, recurrent	1	NA			
25) Toxoplasmosis of brain	1	2			
26) Wasting syndrome due to HIV	1	NA			

Def. = definitive diagnosis Pres. = presumptive diagnosis

*RVCT CASE NO.: [ ][ ][ ][ ][ ][ ][ ][ ][ ][ ]

- **If HIV tests were not positive or were not done, does this patient have an immunodeficiency that would disqualify him/her from the AIDS case definition?** [1] Yes [0] No [9] Unknown

X. TREATMENT/SERVICES REFERRALS

Has this patient been informed of his/her HIV infection? [1] Yes [0] No [9] Unk.

This patient's partners will be notified about their HIV exposure and counseled by:

[1] DIS (Local Health Department) [2] Physician/provider [3] Patient [9] Unk.

[ ] ISDH Surveillance office needs to notify DIS

This patient is receiving or has been referred for:

	Yes	No	Unk.
• HIV-related medical services	1	0	9
• Substance abuse treatment services	1	0	9
• Mental health services	1	0	9

Specify: _____

This patient received or is receiving:

	Yes	No	Unk.
▪ Anti-retroviral therapy	1	0	9
▪ PCP prophylaxis	1	0	9

This patient has been enrolled at:

Clinical Trial	Clinic
[1] NIH-sponsored	[1] HRSA-sponsored
[2] Other	[2] Other
[3] None	[3] None
[9] Unknown	[9] Unknown

This patient's medical treatment is primarily reimbursed by:

[1] Medicaid [2] Private insurance/HMO
[3] No coverage [4] Other Public Funding
[7] Clinical trial/ government program [9] Unknown

XI. POST-TEST COUNSELING

Has the patient been told not to donate blood, plasma, organs, or other body tissue? ..... [1] Yes [0] No [9] Unk. Date _____

Has this patient been told of their duty to warn all sex and needle-sharing partners of their HIV status prior to engaging in this behavior? ..... [1] Yes [0] No [9] Unk. Date _____

MUST COMPLETE:

Name of person that provided post-test counseling _____ Telephone No.: ( ) _____

XII. FOR FEMALES ONLY

Is the patient currently pregnant? ..... [1] Yes [0] No [9] Unk. Date Due [ ][ ] [ ][ ] [ ][ ]

Obstetrician/NP/Clinic/Family Doctor: _____ Telephone No.: ( ) _____

Is the above provider aware of her HIV status? ..... [1] Yes [0] No [9] Unk.

Has the patient been offered information regarding the use of HIV treatment medications during pregnancy? ..... [1] Yes [0] No [9] Unk. [ ] Information offered and patient declined.

Name of Child *(Most recent birth after 1977)*: _____ Date of Birth: _____/_____/_____

Hospital Name: _____ City: _____ State: _____

Has the child been tested for HIV? Yes [ ] No [ ] If yes, what was the result? _____ Was the child born before the mother's last negative HIV test? Yes [ ] No [ ]

XIII. COINFECTION/PARTNERS

COINFECTIONS:	Yes	No	Unk.	Diagnosis Date		Acute	Chronic
Hepatitis B	[ ]	[ ]	[ ]	_____		[ ]	[ ]
Hepatitis C	[ ]	[ ]	[ ]	_____		[ ]	[ ]
Sexually Transmitted Disease (STD)	[ ]	[ ]	[ ]	_____	Specify STD: _____		
Sexually Transmitted Disease (STD)	[ ]	[ ]	[ ]	_____	Specify STD: _____		
Sexually Transmitted Disease (STD)	[ ]	[ ]	[ ]	_____	Specify STD: _____		

Names of known sex or IV drug using partners including spouse(s) of last 10 years:

Name:	Address:	Telephone No.:	Email:
1. _____	_____	_____	_____
2. _____	_____	_____	_____
3. _____	_____	_____	_____
4. _____	_____	_____	_____

XIV. STATE USE ONLY

Census Tract _____

NIR STATUS: This section is used only if a case has been previously entered as NIR or is being entered NIR. Choose response that corresponds to the current status.

NIR: Yes [ ] No [ ]

- [ ] Physician Current
- [ ] Send first reporter packet
- [ ] Address Current
- [ ] CLOSED admin.
- [ ] Sent to DIS Date _____
- [ ] RETURN TO SURVEILLANCE COORDINATOR

Current Status: [ ]

1 = Open (still seeking risk)
2 = Closed – Dead*
3 = Closed – Refused*
4 = Closed – Lost to follow-up*
5 = Investigated (risk still unknown)*
6 = Reclassified (risk has been found)*

*Enter month/year resolved _____/_____

Casework needed to complete report: [ ]

00 = Arrived complete	09 = Entire Case Report
01 = Demographic data	10 = Patient identifier
02 = Residence at Dx	11 = Clinical Status/AIDS or OIs
03 = Hospital/Facility	12 = Treatment/Services/Referral
04 = Risk factor	13 = Post-Test Counseling
05 = Date of first Dx	14 = Female Only
06 = Laboratory data	15 = Co-infections–STD/HEP/TB etc
07 = Physician info	16 = Partners
08 = Case report	17 = Other

Current Status: [ ]

1 = 1-2 calls/letters
2 = 2-4 calls
3 = 5-10 calls
4 = Investigated – to DIS (See NIR section)
5 =Other: _____

Surveillance Coordinator initials _____

Follow-up date _____

Follow-up plan _____

XV. HIV TESTING HISTORY

STATE USE ONLY Reviewed by (initials) ____

Date of interview/questionnaire completion (mo/day/yr): _____/_____/_____

FIRST POSITIVE HIV TEST

Date (mo/yr): _____/_____ Was test anonymous?: [1] Yes [0] No [7] Refused [9] Unknown

Site name: _____ State: _____

Circle type of facility:

1-HIV counseling/testing
2-STD clinic
3-Drug treatment clinic
4-Family planning clinic
5-Prenatal/OB clinic
6-TB clinic
7-Community health clinic
8-Prison/jail
9-Hospital/private MD
10-Blood bank
11-Outreach/mobile
12-Emergency room
13-Other

Reason for HIV testing when first positive (answer all):

	Yes	No		Yes	No
1-Possible exposure to HIV in past 6 months	1	0	4-Required by court, military, insurance, etc.	1	0
2-Time for regular test	1	0	5-Other _____	1	0
3-Checking to make sure negative	1	0			

FIRST EVER HIV TEST

Date (mo/yr) (regardless of result): _____/_____

LAST NEGATIVE HIV TEST

[ ] Never had negative HIV test [7] Refused [9] Unknown *(Skip to next section.)*

Date (mo/yr): _____/_____ Site name: _____ State: _____

Circle type of facility:

1-HIV counseling/testing
2-STD clinic
3-Drug treatment clinic
4-Family planning clinic
5-Prenatal/OB clinic
6-TB clinic
7-Community health clinic
8-Prison/jail
9-Hospital/private MD
10-Blood bank
11-Outreach/mobile
12-Emergency room
13-Other

OTHER HIV TESTS

Number of HIV tests in 2 years before first positive (include first positive result):

1	+	_____	=	_____
first positive test		# of negative tests during prior 2 years		total # of tests in 2 years

ANTIRETROVIRAL USE BEFORE DIAGNOSIS OF HIV

	Yes	No	Ref	Unk
Used ARV in 6 months before diagnosis:	1	0	7	9

If yes, names of ARV medications used: _____

(*Continue in comments if necessary)*

First date of ARV use (mo/day/yr): _____/_____/_____

	Yes	No	Ref	Unk
Currently using ARV:	1	0	7	9

If no, last date of ARV use (mo/day/yr): _____/_____/_____

COMMENTS:

(Attach additional sheet if needed.)